THE SENATE
TWENTY-FOURTH LEGISLATURE, 2007
STATE OF HAWAII

S.B. NO. 701

JAN 19 2007

A BILL FOR AN ACT

RELATING TO HEALTH.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF HAWAII:

SECTION 1. Chapter 324, Hawaii Revised Statutes, is amended by adding a new section to be appropriately designated and to read as follows:

"**§324- Adverse events; data collection and reporting.** (a) The department of health shall adopt rules under chapter 91 that require the department to collect and analyze data on the number and type of adverse events that occur in health care facilities in the State.

As used in this section, "health care facility" includes "health care facility" and "organized ambulatory health care facility" as those terms are defined in section 323D-2.

As used in this section, "adverse event" includes any of the following:

(1) Surgical events, including the following:

(A) Surgery performed on a wrong body part that is inconsistent with the documented informed consent for that patient. A reportable event under this subparagraph does not include a situation

requiring prompt action that occurs in the course of surgery or a situation that is so urgent as to preclude obtaining informed consent;

(B) Surgery performed on the wrong patient;

(C) The wrong surgical procedure performed on a patient, which is a surgical procedure performed on a patient that is inconsistent with the documented informed consent for that patient. A reportable event under this subparagraph does not include a situation requiring prompt action that occurs in the course of surgery, or a situation that is so urgent as to preclude the obtaining of informed consent;

(D) Retention of a foreign object in a patient after surgery or other procedure, excluding objects intentionally implanted as part of a planned intervention and objects present prior to surgery that are intentionally retained; and

(E) Death during or up to twenty-four hours after induction of anesthesia after surgery of a normal, healthy patient who has no organic, physiologic, biochemical, or psychiatric

disturbance and for whom the pathologic processes for which the operation is to be performed are localized and do not entail a systemic disturbance.

(2) Product or device events, including the following:

(A) Patient death or serious disability associated with the use of a contaminated drug, device, or biologic provided by the health facility when the contamination is the result of generally detectable contaminants in the drug, device, or biologic, regardless of the source of the contamination or the product;

(B) Patient death or serious disability associated with the use or function of a device in patient care in which the device is used or functions other than as intended. For purposes of this subparagraph, "device" includes, but is not limited to, a catheter, drain, or other specialized tube, infusion pump, or ventilator; and

(C) Patient death or serious disability associated with intravascular air embolism that occurs while

being cared for in a facility, excluding deaths associated with neurosurgical procedures known to present a high risk of intravascular air embolism.

(3) Patient protection events, including the following:

(A) An infant discharged to the wrong person;

(B) Patient death or serious disability associated with patient disappearance for more than four hours, excluding events involving adults who have competency or decision-making capacity; and

(C) A patient suicide or attempted suicide resulting in serious disability while being cared for in a health facility due to patient actions after admission to the health facility, excluding deaths resulting from self-inflicted injuries that were the reason for admission to the health facility.

(4) Care management events, including the following:

(A) A patient death or serious disability associated with a medication error, including, but not limited to, an error involving the wrong drug, the wrong dose, the wrong patient, the wrong

time, the wrong rate, the wrong preparation, or the wrong route of administration, excluding reasonable differences in clinical judgment on drug selection and dose;

(B) A patient death or serious disability associated with a hemolytic reaction due to the administration of blood type-incompatible blood or blood products;

(C) Maternal death or serious disability associated with labor or delivery in a low-risk pregnancy while being cared for in a facility, including events that occur within forty-two days post delivery and excluding deaths from pulmonary or amniotic fluid embolism, acute fatty liver of pregnancy, or cardiomyopathy;

(D) Patient death or serious disability directly related to hypoglycemia, the onset of which occurs while the patient is being cared for in a health facility;

(E) Death or serious disability, including kernicterus, associated with failure to identify and treat hyperbilirubinemia in neonates during

the first twenty-eight days of life. For purposes of this subparagraph, "hyperbilirubinemia" means bilirubin levels greater than thirty milligrams per deciliter;

(F) A stage 3 or stage 4 ulcer, acquired after admission to a health facility, excluding progression from Stage 2 to Stage 3 if Stage 2 was recognized upon admission; and

(G) A patient death or serious disability due to spinal manipulative therapy performed at the health facility.

(5) Environmental events, including the following:

(A) A patient death or serious disability associated with an electric shock while being cared for in a health facility, excluding events involving planned treatments, such as electric counter shock;

(B) Any incident in which a line designated for oxygen or other gas to be delivered to a patient contains the wrong gas or is contaminated by a toxic substance;

(C) A patient death or serious disability associated with a burn incurred from any source while being cared for in a health facility;

(D) A patient death associated with a fall while being cared for in a health facility; and

(E) A patient death or serious disability associated with the use of restraints or bedrails while being cared for in a health facility.

(6) Criminal events, including the following:

(A) Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed health care provider;

(B) The abduction of a patient of any age;

(C) The sexual assault on a patient within or on the grounds of a health facility; and

(D) The death or significant injury of a patient or staff member resulting from a physical assault that occurs within or on the grounds of a facility.

(7) An adverse event or series of adverse events that cause the death or serious disability of a patient, personnel, or visitor.

(b) The department shall use the information and results of the data and analysis under this section for the purposes of developing and implementing policies to reduce the occurrence of adverse events in health care facilities in the State.

(c) The director of health shall submit an annual report to the governor and the legislature at least twenty days prior to the convening of each regular session detailing the type and frequency of adverse events and where they occurred during the previous year. The director shall make this annual report accessible to the public on the department of health website."

SECTION 2. New statutory material is underscored.

SECTION 3. This Act shall take effect upon its approval.

INTRODUCED BY: _____

S.B. NO. 701

Report Title:
Health Care Facilities; Adverse Events; Reporting

Description:
Requires department of health to collect data and submit annual reports on the number of adverse events in health care facilities in the State.